

1 LABOR CABINET

2 Department of Workers' Claims

3 (Amended After Comments)

4 803 KAR 25:190. Utilization review -- Medical Bill Audit -- Medical Director -- Appeal of
5 Utilization Review Decisions.

6 RELATES TO: KRS Chapter 342

7 STATUTORY AUTHORITY: KRS 342.035(5) and (6), 342.260

8 NECESSITY, FUNCTION, AND CONFORMITY: KRS 342.260 provides that the
9 Commissioner [~~Executive Director~~] of the Department [~~Office~~] of Workers' Claims shall
10 promulgate administrative regulations necessary to carry on the work of the Department [~~Office~~]
11 of Workers' Claims, and the commissioner [~~executive-director~~] may promulgate administrative
12 regulations not inconsistent with the provisions of KRS Chapter 342. KRS 342.035(5) provides
13 that the commissioner [~~Executive Director~~] of the Department [~~Office~~] of Workers' Claims shall
14 promulgate administrative regulations that require each insurance carrier, group self-insurer and
15 individual self-insured employer to certify to the commissioner [~~executive-director~~] the program
16 it has adopted to insure compliance with the medical fee schedule provisions of KRS 342.035(1)
17 and (4). KRS 342.035(5) also requires the commissioner [~~executive-director~~] to promulgate
18 administrative regulations governing medical provider utilization review activities conducted by
19 an insurance carrier, group self-insurer or self-insured employer pursuant to KRS Chapter 342.

1 KRS 342.035(6) allows the commissioner to promulgate regulations incorporating
2 managed care or other concepts intended to reduce costs or to speed the delivery of payment of
3 medical services to employees receiving medical and related benefits under KRS Chapter 342.
4 This administrative regulation insures that insurance carriers, group self-insurers, and individual
5 self-insured employers implement a utilization review and audit program and establishes a medical
6 director to speed the delivery of payment of medical services to employees receiving medical and
7 related benefits under this chapter. This administrative regulation does not abrogate the right, as
8 provided in KRS 342.020, of an injured employee to choose his treating physician, or an employer
9 to participate in a managed health care system.

10 Section 1. Definitions. (1) "Business day" means any day except Saturday, Sunday or any
11 day which is a legal holiday.

12 (2) "Calendar day" means all days in a month, including Saturday, Sunday and any day
13 which is a legal holiday.

14 (3) "Carrier" is defined by KRS 342.0011(6).

15 (4) [(2)] "Commissioner" is defined by KRS 342.0011(9).

16 (5) [(3)] "Denial" means a determination by the utilization reviewer that the medical
17 treatment, proposed treatment, service, or medication [or ~~service~~] under review is not medically
18 necessary or appropriate and, therefore, payment is not recommended.

19 (6) "Department" means the Kentucky Department of Workers' Claims.

1 (7) [(4)] "Medical bill audit" means the review of medical bills for services which have
2 been provided to assure compliance with adopted fee schedules.

3 (8) "Medical Director" means the Medical Director of the Department of Workers' Claims
4 appointed by the Secretary.

5 (9) "Medically necessary" or "medical necessity" is defined in 803 KAR 25:260(12).

6 (10). "Medical provider" is defined in 803 KAR 25:260 Section 1(11).

7 (11) "Physician" is defined by KRS 342.0011(32).

8 (12) [(5)] "Preauthorization" is defined in 803 KAR 25:260(14). means a process whereby
9 payment for a medical service or course of treatment is assured in advance by a carrier.

10 (13) "Secretary" means the Secretary of the Kentucky Labor Cabinet.

11 (14) [(6)] "Utilization review" means a review of the medical necessity and appropriateness
12 of medical care and services for purposes of recommending payments for a compensable injury or
13 disease.

14 (15) [(7)] "Utilization review and medical bill audit plan" means the written plan submitted
15 to the commissioner [executive director] by each carrier describing the procedures governing
16 utilization review and medical bill audit activities.

17 (16) [(8)] "Vendor" means a person or entity which implements a utilization review and
18 medical bill audit program for purposes of offering those services to carriers.

1 Section 2. Implementation. (1) The requirements established in Sections 3 through 9 of
2 this administrative regulation shall apply to all utilization reviews and medical bill audits
3 conducted before June ~~January~~ 1, 2022.

4 (2) The requirements established in Sections 10 through 18 of this administrative regulation
5 shall apply to all utilization reviews and medical bill audits conducted on or after June ~~January~~
6 1, 2022.

7 Section 3 [2]. Utilization Review and Medical Bill Audit Program. (1) The utilization
8 review program shall assure that:

9 (a) A utilization reviewer is appropriately qualified;

10 (b) Treatment rendered to an injured worker is medically necessary and appropriate; and

11 (c) Necessary medical services are not withheld or unreasonably delayed.

12 (2) The medical bill audit program shall assure that:

13 (a) A statement or payment for medical goods and services and charges for a deposition,
14 report, or photocopy complies with KRS Chapter 342 and applicable administrative regulations;

15 (b) A medical bill auditor is appropriately qualified; and

16 (c) A statement for medical services is not disputed without reasonable grounds.

17 Section 4 [3]. Utilization Review and Medical Bill Audit Plan Approval. (1) A carrier shall
18 fully implement and maintain a utilization review and medical bill audit program.

1 (2) A carrier shall provide to the commissioner [~~executive-director~~] a written plan
2 describing the utilization re-view and medical bill audit program. The commissioner [~~executive~~
3 ~~director~~] shall approve each utilization review and medical bill audit plan which complies with the
4 requirements of this administrative regulation and KRS Chapter 342.

5 (3) A vendor shall submit to the commissioner [~~executive-director~~] for approval a written
6 plan describing the utilization review and medical bill audit program. Upon approval, the vendor
7 shall receive written notice from the commissioner [~~executive-director~~].

8 (4) A carrier who contracts with an approved vendor for utilization review or medical bill
9 audit services shall notify the commissioner [~~executive-director~~] of the contractual arrangement.
10 The contractual arrangement may provide for separate utilization review and medical bill audit
11 vendors.

12 (5) A plan shall be approved for a period of four (4) years [~~, or until December 31, 2000,~~
13 ~~whichever is later~~].

14 (a) At least ninety (90) calendar days prior to the expiration of the period of approval, a
15 carrier or its approved vendor shall apply for renewal of the approval.

16 (b) During the term of an approved plan, the commissioner [~~executive-director~~] shall be
17 notified as soon as practicable of a material change in the approved plan or a change in the selection
18 of a vendor.

1 Section 5 [4]. Utilization Review and Medical Bill Audit Written Plan Requirements. The
2 written utilization review and medical bill audit plan submitted to the commissioner [~~executive~~
3 ~~director~~] shall include the following elements:

4 (1) A description of the process, policies and procedures whereby decisions shall be made;

5 (2) A description of the specific criteria utilized in the decision making process, including
6 a description of the specific medical guidelines used as the resource to confirm the medical
7 diagnosis and to provide consistent criteria and practice standards against which care quality and
8 related costs are measured;

9 (3) A description of the criteria by which claims, medical services and medical bills shall
10 be selected for review;

11 (4) A description of the qualifications of internal and consulting personnel who shall
12 conduct utilization review and medical bill audit and the manner in which the personnel shall be
13 involved in the review process;

14 (5) A description of the process to assure that a treatment plan shall be obtained for review
15 by qualified medical personnel if a treatment plan is required by 803 KAR 25:096;

16 (6) A description of the process to assure that a physician shall be designated by each
17 injured employee as required under 803 KAR 25:096;

18 (7) A description of the process for rendering and promptly notifying the medical provider
19 and employee of the initial utilization review decision;

1 (8) A description of the reconsideration process within the structure of the utilization
2 review and medical bill audit program;

3 (9) An assurance that a database shall be maintained, which shall:

4 (a) Record:

5 1. Each instance of utilization review;

6 2. Each instance of medical bill audit;

7 3. The name of the reviewer;

8 4. The extent of the review;

9 5. The conclusions of the reviewer; and

10 6. The action, if any, taken as the result of the review;

11 (b) Be maintained for a period of at least two (2) years; and

12 (c) Be subject to audit by the commissioner [~~executive director~~], or his agent, pursuant to
13 KRS 342.035(5)(b);

14 (10) An assurance that a toll free line shall be provided for an employee or medical provider
15 to contact the utilization reviewer. The reviewer or a representative of the reviewer shall be
16 reasonably accessible to an interested party at least five (5) days per week, forty (40) hours per
17 week during normal business hours;

1 (11) A description of the policies and procedures that shall be implemented to protect the
2 confidentiality of patient information; and

3 (12) An assurance that medical treatment guidelines adopted by the commissioner pursuant
4 to KRS 342.035 (8)(a) shall be incorporated in the plan as the standard for utilization review
5 medical decision making. ~~[An assurance that the acute low back pain practice parameter adopted~~
6 ~~by the executive director pursuant to KRS 342.035(8)(a) shall be incorporated in the plan as the~~
7 ~~standard for evaluating an applicable low back claim. Additional medical guidelines which may~~
8 ~~be adopted by the executive director pursuant to KRS 342.035(8)(a) shall be incorporated in a~~
9 ~~utilization review plan.]~~

10 Section 6 [5]. Claim Selection Criteria. (1) Unless the carrier, in good faith, denies the
11 claim as noncompensable, medical services reasonably related to the claim shall be subject to
12 utilization review if:

13 (a) A medical provider requests preauthorization of a medical treatment or procedure;

14 (b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR
15 25:096 treatment plan is received;

16 (c) The total medical costs cumulatively exceed \$3000;

17 (d) The total lost work days cumulatively exceed thirty (30) days; or

18 (e) An arbitrator or administrative law judge orders a review.

1 (2) If applicable, utilization review shall commence when the carrier has notice that a
2 claims selection criteria has been met.

3 (a) The following requirements shall apply if preauthorization has been requested:

4 1. The initial utilization review decision shall be communicated to the medical provider
5 and employee within two (2) business [~~working~~] days of the initiation of the utilization review
6 process, unless additional information is required. If additional information is required, tender of
7 a single request shall be made within two (2) additional business [~~working~~] days.

8 2. The requested information shall be tendered by the medical provider within ten (10)
9 business [~~working~~] days.

10 3. The initial utilization review decision shall be rendered within two (2) business
11 [~~working~~] days following receipt of the requested information.

12 (b) The following requirements shall apply if retrospective utilization review occurs:

13 1. The initial utilization review decision shall be communicated to the medical provider
14 and employee within ten (10) calendar days of the initiation of the utilization review process,
15 unless additional information is required. If additional information is required, tender of a single
16 request shall be made within two (2) additional business [~~working~~] days.

17 2. The requested information shall be tendered by the medical provider within ten (10)
18 business [~~working~~] days.

1 3. The initial utilization review decision shall be rendered within two (2) business
2 [working] days following receipt of the requested information.

3 (3) A medical provider may request an expedited utilization review determination for
4 proposed medical treatment or services, the lack of which could reasonably be expected to lead to
5 serious physical or mental disability or death. The expedited utilization review determination shall
6 be provided within twenty-four (24) hours following a request for expedited review.

7 (4) Initiation of utilization review shall toll the thirty (30) day period for challenging or
8 paying medical expenses pursuant to KRS 342.020(1). The thirty (30) day period shall commence
9 on the date of the final utilization review decision.

10 (5) Each medical bill audit shall be initiated within seven (7) calendar days of receipt to
11 assure:

12 (a) Compliance with applicable fee schedules;

13 (b) Accuracy; and

14 (c) That a physician has been designated in accordance with 803 KAR 25:096.

15 (6) A medical bill audit shall not toll the thirty (30) day period for challenging or paying
16 medical expenses pursuant to KRS 342.020(1).

17 Section 7 [6]. Utilization Review and Medical Bill Audit Personnel Qualifications. (1)
18 Utilization review personnel shall have education, training, and experience necessary for
19 evaluating the clinical issues and services under review. A physician, registered nurse, licensed

1 practical nurse, medical records technician or other personnel, who through training and
2 experience is qualified to issue decisions on medical necessity or appropriateness, shall issue the
3 initial utilization review approval.

4 (2) A physician shall issue an initial utilization review denial. A physician shall supervise
5 utilization review personnel in making utilization review recommendations. Personnel shall hold
6 the license required by the jurisdiction in which they are employed.

7 (3) Personnel conducting a medical bill audit shall have the education, training or
8 experience necessary for evaluating medical bills and statements.

9 Section 8 [7]. Written Notice of Denial. (1) Following initial review, a written notice of
10 denial shall:

11 (a) Be issued to both the medical provider and the employee in a timely manner but no
12 more than ten (10) calendar days from the initiation of the utilization review process;

13 (b) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and

14 (c) Contain:

15 1. A statement of the medical reasons for denial;

16 2. The name, state of licensure and medical license number of the reviewer; and

17 3. An explanation of utilization review reconsideration rights.

1 (2) Payment for medical services shall not be denied on the basis of lack of information
2 absent documentation of a good faith effort to obtain the necessary information.

3 Section 9 [8]. Reconsideration. (1) A reconsideration process to appeal an initial decision
4 shall be provided within the structure of utilization review.

5 (a) A request for reconsideration of the initial utilization review decision shall be made by
6 an aggrieved party within fourteen (14) calendar days of receipt of a written notice of denial.

7 (b) Reconsideration of the initial utilization review decision shall be conducted by a
8 different reviewer of at least the same qualifications as the initial reviewer.

9 (c) A written reconsideration decision shall be rendered within ten (10) calendar days of
10 receipt of a request for reconsideration. The written decision shall be clearly entitled
11 "UTILIZATION REVIEW - RECONSIDERATION DECISION". If the reconsideration decision
12 is made by an appropriate specialist or subspecialist, the written decision shall further be entitled
13 "FINAL UTILIZATION REVIEW DECISION".

14 (d) Those portions of the medical record that are relevant to the reconsideration, if
15 authorized by the patient and in accordance with state or federal law, shall be considered and
16 providers shall be given the opportunity to present additional information.

17 (2)(a) If a utilization review denial is upheld upon reconsideration and a board eligible or
18 certified physician in the appropriate specialty or subspecialty area, or a chiropractor qualified

pursuant to KRS 312.200(3) and 201 KAR 21:095 has not previously reviewed the matter, an aggrieved party may request further review by:

1. A board eligible or certified physician in the appropriate specialty or subspecialty; or

2. A chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.

(b) A written decision shall be rendered within ten (10) calendar days of the request for specialty reconsideration. The specialty decision shall be clearly entitled "FINAL UTILIZATION REVIEW DECISION".

(3) A reconsideration process to appeal an initial decision shall be provided within the structure of medical bill audit.

(a) A request for reconsideration of the medical bill audit decision shall be made by an aggrieved party within fourteen (14) calendar days of receipt of that decision.

(b) Reconsideration shall be conducted by a different reviewer of at least the same qualifications as the initial reviewer.

(c) A written decision shall be rendered within ten (10) calendar days of receipt of a request for reconsideration. The written decision shall be clearly entitled "MEDICAL BILL AUDIT RECONSIDERATION DECISION".

(d) A request for reconsideration of the medical bill audit decision shall not toll the thirty (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1).

1 Section 10. Utilization Review and Medical Bill Audit Program. (1) The utilization review
2 program shall assure that:

3 (a) A utilization reviewer is appropriately qualified;

4 (b) Treatment rendered to an injured worker is medically necessary and appropriate; and

5 (c) Necessary medical services are not withheld or unreasonably delayed.

6 (2) The medical bill audit program shall assure that:

7 (a) A statement or payment for medical goods and services and charges for a deposition,
8 report, or photocopy complies with KRS Chapter 342 and applicable administrative regulations;

9 (b) A medical bill auditor is appropriately qualified; and

10 (c) A statement for medical services is not disputed without reasonable grounds.

11 Section 11. Utilization Review and Medical Bill Audit Plan Approval. (1) A carrier shall
12 fully implement and maintain a utilization review and medical bill audit program.

13 (2) A carrier shall provide to the commissioner a written plan describing the utilization
14 review and medical bill audit program. The commissioner shall approve each utilization review
15 and medical bill audit plan which complies with the requirements of this administrative regulation
16 and KRS Chapter 342.

1 (3) A vendor shall submit to the commissioner for approval a written plan describing the
2 utilization review and medical bill audit program. Upon approval, the vendor shall receive written
3 notice from the commissioner.

4 (4) A carrier who contracts with an approved vendor for utilization review or medical bill
5 audit services shall notify the commissioner of the contractual arrangement. The contractual
6 arrangement may provide for separate utilization review and medical bill audit vendors.

7 (5) A plan shall be approved for a period of four (4) years.

8 (a) At least ninety (90) calendar days prior to the expiration of the period of approval, a
9 carrier or its approved vendor shall apply for renewal of the approval.

10 (b) During the term of an approved plan, the commissioner shall be notified as soon as
11 practicable of a material change in the approved plan or a change in the selection of a vendor.

12 (6) A carrier, who contracts with an approved vendor for utilization review services, shall
13 provide annually to the commissioner summaries of the number of utilizations reviews, waivers
14 per KRS 342.035(5)(c), utilization review approvals for treatment, utilization review denials for
15 treatment and appeals to the medical director. Such annual reports of the approved vendor shall be
16 filed with the Department by August 1 for the preceding fiscal year ending June 30.

17 Section 12. Utilization Review and Medical Bill Audit Written Plan Requirements. The
18 written utilization review and medical bill audit plan submitted to the commissioner shall include
19 the following elements:

1 (1) A description of the process, policies and procedures whereby decisions shall be made;

2 (2) A description of the specific criteria utilized in the decision making process, including
3 a description of the specific medical guidelines used as the resource to confirm the medical
4 diagnosis and to provide consistent criteria and practice standards against which care quality and
5 related costs are measured;

6 (3) A description of the criteria by which claims, medical services and medical bills shall
7 be selected for review;

8 (4) A description of the qualifications of internal and consulting personnel who shall
9 conduct utilization review and medical bill audit and the manner in which the personnel shall be
10 involved in the review process;

11 (5) A description of the process to assure that a treatment plan shall be obtained for review
12 by qualified medical personnel if a treatment plan is required by 803 KAR 25:096;

13 (6) A description of the process to assure that a physician shall be designated by each
14 injured employee as required under 803 KAR 25:096;

15 (7) A description of the process for rendering and promptly notifying the medical provider
16 and employee of the initial utilization review decision;

17 (8) A description of the reconsideration process within the structure of the utilization
18 review and medical bill audit program;

19 (9) An assurance that a database shall be maintained, which shall:

1 (a) Record:

2 1. Each instance of utilization review;

3 2. Each instance of medical bill audit;

4 3. The name of the reviewer;

5 4. The extent of the review;

6 5. The conclusions of the reviewer; and

7 6. The action, if any, taken as the result of the review;

8 (b) Be maintained for a period of at least two (2) years; and

9 (c) Be subject to audit by the commissioner, or his agent, pursuant to KRS 342.035(5)(b);

10 (10) An assurance that a toll free line shall be provided for an employee or medical provider
11 to contact the utilization reviewer. The reviewer or a representative of the reviewer shall be
12 reasonably accessible to an interested party at least five (5) days per week, forty (40) hours per
13 week during normal business hours;

14 (11) A description of the policies and procedures that shall be implemented to protect the
15 confidentiality of patient information; and

16 (12) An assurance that medical treatment guidelines adopted by the commissioner pursuant
17 to KRS 342.035 (8)(a) shall be incorporated in the plan as the standard for utilization review
18 medical decision making.

1 Section 13. Claim Selection Criteria and Process.

2 (1) Unless the medical payment obligor, in good faith, denies the claim as noncompensable
3 or waives utilization review pursuant to KRS 342.035 (5)(c) , medical services reasonably related
4 or asserted to be related to the claim shall be subject to utilization review if:

5 (a) A medical provider requests preauthorization of a medical treatment or procedure;

6 (b) Notification of a surgical procedure or resident placement pursuant to an 803 KAR
7 25:096 treatment plan is received;

8 (c) The total medical costs cumulatively exceed \$1000; or

9 (d) The total lost work days cumulatively exceed fifteen (15) days.

10 (2) Utilization review shall commence when the medical payment obligor has notice that a
11 claims selection criteria has been met. The medical payment obligor may waive utilization review
12 pursuant to KRS 342.035(5)(c) within two (2) business days of such notice. Failure by the medical
13 payment obligor to waive and communicate its waiver to the employee and medical provider or
14 initiate its utilization review process within two (2) business days shall result in the medical
15 payment obligor paying for the subject medical services pursuant to the appropriate fee schedules.

16 (a) The following requirements shall apply if preauthorization has been requested and
17 utilization review has not been waived:

18 1. The utilization review decision shall be rendered and communicated to the medical
19 provider and employee, and the employee's attorney if represented, within two (2) business

1 days of the initiation of the utilization review process, unless additional information is required. If
2 additional information is required, tender of a single request shall be made within two (2)
3 additional business days.

4 2. The requested information shall be tendered by the medical provider within five (5)
5 business days.

6 3. The utilization review decision shall be rendered and communicated within two (2)
7 business days following receipt of the requested information.

8 **(b) The following requirements shall apply if retrospective utilization review occurs:**

9 1. The utilization review decision shall be rendered and communicated to the medical
10 provider and employee, **and the employee's attorney if represented**, within five (5) business
11 days of the initiation of the utilization review process, unless additional information is required. If
12 additional information is required, tender of a single request shall be made within two (2)
13 additional business days.

14 2. The requested information shall be tendered by the medical provider within five (5)
15 business days.

16 3. The utilization review decision shall be rendered and communicated within two (2)
17 business days following receipt of the requested information.

18 **(3) A medical provider may request an expedited utilization review determination for**
19 proposed medical treatment or services, the lack of which could reasonably be expected to lead to

1 serious physical or mental disability or death. The expedited utilization review determination shall
2 be rendered and communicated within twenty-four (24) hours following a request for expedited
3 review.

4 (4) Initiation of utilization review shall toll the thirty (30) day period for paying medical
5 expenses pursuant to KRS 342.020(4). The thirty (30) day period for paying medical expenses
6 shall commence on the date of the utilization review decision.

7 (5) Each medical bill audit shall be initiated within seven (7) calendar days of receipt to
8 assure:

9 (a) Compliance with applicable fee schedules;

10 (b) Accuracy; and

11 (c) That a physician has been designated in accordance with 803 KAR 25:096.

12 (6) A medical bill audit shall not toll the thirty (30) day period for challenging or paying
13 medical expenses pursuant to KRS 342.020(4).

14 Section 14. Utilization Review and Medical Bill Audit Personnel Qualifications.

15 (1) Utilization review personnel shall have education, training, and experience necessary
16 for evaluating the clinical issues and services under review. A physician, registered nurse, licensed
17 practical nurse, medical records technician or other personnel, who through training and
18 experience is qualified to issue decisions on medical necessity or appropriateness, shall issue the
19 initial utilization review approval.

1 (2) A physician shall issue an initial utilization review denial. A physician shall supervise
2 utilization review personnel in making utilization review recommendations. Personnel shall hold
3 the license required by the jurisdiction in which they are employed.

4 (3) Personnel conducting a medical bill audit shall have the education, training or
5 experience necessary for evaluating medical bills and statements.

6 Section 15. Written Notice of Denial.

7 (1) Following utilization review, a written notice of denial shall:

8 (a) Be clearly entitled "UTILIZATION REVIEW - NOTICE OF DENIAL"; and

9 (b) Contain:

10 1. A statement of the medical reasons for denial;

11 2. The name, state of licensure and medical license number of the reviewer; and

12 3. An explanation of utilization appeal rights with instructions on how to proceed with an
13 appeal.

14 (2) The Department shall develop and provide a form on its website that a medical payment
15 obligor may use to comply with Section 15 (1) above.

16 (3) A copy of the written notice of denial along with the mailing address, telephone number,
17 and, if known, the email address of the employee, the employee's attorney if represented, and
18 medical provider whose treatment, recommended treatment, or prescribed medication is being

1 denied shall be sent by electronic mail to the medical director on the same day that the notice of
2 denial is rendered and communicated to that medical provider and employee. The medical director
3 shall then immediately notify the employee, the employee's attorney if represented, and that
4 medical provider of the actions required to appeal the utilization review denial at no cost to the
5 employee.

6 (4) Payment for medical services shall not be denied on the basis of lack of information
7 absent documentation of a good faith effort to obtain the necessary information.

8 Section 16. Medical Director.

9 (1) After consultation with the Commissioner, the [The] Secretary shall appoint a
10 medical director to:

11 (a) process appeals of utilization review decisions and medical bill audit decisions rendered
12 pursuant to this regulation, and

13 (b) at least annually, review and advise the commissioner and the Secretary on the
14 effectiveness of the Medical Fee Schedule for Physicians, the Treatment Guidelines and the
15 Pharmaceutical Formulary in reducing costs and speeding the delivery of medical services to
16 employees receiving medical benefits under KRS Chapter 342.

17 (2) The medical director shall be a Kentucky licensed physician in good standing with the
18 Kentucky Board of Medical Licensure.

1 (3) The medical director may, when appropriate, seek the assistance of other physicians to
2 assist or perform any tasks outlined within this regulation. **When the treatment under appeal is**
3 **chiropractic treatment, the medical director shall seek the assistance of a chiropractor**
4 **qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.**

5 (4) The medical director shall chair a Workers' Compensation Medical Advisory
6 Committee to provide advice on issues related to the medical treatment of injured workers. The
7 medical director may request the committee to advise on the medical aspects of the Department's
8 various programs in advancing the goal of ensuring that all injured employees receive superior
9 quality and cost efficient treatment to facilitate recovery from injury and a swift, safe return to the
10 workforce.

11 (a) In addition to the medical director serving as chair, the commissioner shall serve on the
12 Workers' Compensation Medical Advisory Committee and may appoint the following to the
13 Workers' Compensation Medical Advisory Committee: deputy commissioner, and a
14 representative for employers, employees, labor unions, insurance, self-insured, occupational
15 medicine, chiropractic, orthopedics, neurosurgery, psychiatric, pain management rehabilitation,
16 pain management, emergency medicine, a hospital representative and a pharmacy
17 representative.

18 (b) No less than annually, the Workers' Compensation Medical Advisory Committee shall
19 provide the commissioner and Secretary with a report concerning the activity, effectiveness and

1 impact of the medical director and the utilization review programs on the delivery of payment of
2 medical services to injured employees.

3 Section 17. Appeals of Utilization Review Decisions.

4 (1) Upon receipt of a written notice of denial of treatment subject to utilization review, the
5 employee or medical provider whose treatment, recommended treatment, or prescribed
6 medication, is being denied may appeal the utilization review decision to the medical director.

7 (2) The employee or medical provider whose treatment, recommended treatment, or
8 prescribed medication is being denied shall have **forty-five (45)** [~~thirty (30)~~] calendar days from
9 receipt of the written notice of denial to appeal the utilization review decision to the medical
10 director. The medical director may extend the time to appeal for good cause.

11 (3) Failure to appeal to the medical director shall result in the utilization review decision
12 having preclusive effect as to the reasonableness and necessity of the treatment.

13 (4) An appeal to the medical director shall toll the thirty (30) day period for paying
14 medical expenses pursuant to KRS 342.020(4). The thirty (30) day period to pay the approved
15 medical expenses shall commence on the date of the medical director's written determination or
16 the date on which the parties reach agreement regarding disputed treatment.

17 (5) The Department shall charge a fee of \$400.00 for each appeal submitted to the medical
18 director. The fee shall be paid by the medical payment obligor no later than fifteen (15) calendar
19 days following the date of the appeal to the medical director. Failure to pay the fee shall constitute

1 a failure to complete a necessary step in the administrative review process and be construed as an
2 admission by the employer that the denial was in error and the medical director should find
3 accordingly. Failure to pay the fee may also result in assessment of a civil penalty pursuant to KRS
4 342.990(7)(e).

5 (6) Within five (5) calendar days of the appeal to the medical director, the medical payment
6 obligor may cause the appeal to be dismissed by providing notice to the medical director, medical
7 provider whose treatment, recommended treatment, or prescribed medication is being denied and
8 employee. With such a dismissal, the medical payment obligor shall authorize the payment of the
9 questioned services pursuant to the appropriate fee schedule. If such dismissal occurs, no fee as
10 required by this regulation shall be due, or if paid, the fee shall be refunded to the medical payment
11 obligor.

12 (7) Upon receipt of an appeal request by an employee or medical provider whose treatment
13 or recommended treatment is being denied:

14 (a) The medical director shall conduct the utilization review appeal.

15 (b) The medical director may contact the medical provider whose treatment, recommended
16 treatment, or prescribed medication is being denied for the purpose of obtaining any necessary
17 missing information. Necessary information shall be considered missing until the medical
18 director has obtained:

1 1. All of the records reviewed by the physician that issued the utilization review
2 denial; and

3 2. All medical treatment records from the date of the injury or for the two year period
4 preceding the date of the utilization review, whichever is shorter, for the injury or
5 occupational disease giving rise to the treatment, recommended treatment, or prescribed
6 medication for which the utilization review denial was issued.

7 (c) Within seven (7) calendar days from receipt of the appeal, the [The] medical
8 director shall set a date on which all relevant information shall be due to the medical director.

9 (d) The medical director shall determine the medical necessity of the treatment,
10 recommended treatment, or prescribed medication within fourteen (14) calendar days after receipt
11 of all necessary information by the medical director.

12 (e) Upon determination that any or all of the treatment, recommended treatment, or
13 prescribed medication is reasonable and necessary, the medical director shall plainly state the
14 reasons for each approval in a written determination.

15 (f) Upon determination that any or all of the treatment, recommended treatment, or
16 prescribed medication is not reasonable and necessary, the medical director shall plainly state the
17 reasons for each denial in a written determination.

18 (g) No later than two (2) days after the medical director has made a determination,
19 the [The] medical director shall transmit the written determination to the medical provider whose

1 treatment, recommended treatment, or prescribed medication, is being denied, the employee, the
2 employee's attorney if represented, the employer and the medical payment obligor by facsimile,
3 electronic mail or the United States Postal Service ~~[within fourteen (14) calendar days after~~
4 receipt of all necessary information by the medical director].

5 (h) Additionally, upon a determination by the medical director that there was no reasonable
6 basis upon which to deny the treatment, recommended treatment, or prescribed medication, or that
7 the medical payment obligor failed to follow the required utilization review procedure, the medical
8 director shall request that sanctions be imposed on the medical payment obligor by directing the
9 employee's or physician's costs of the appeal, including reasonable attorney's fees, be paid by the
10 medical payment obligor. Whether or not to impose the aforementioned sanctions is within the
11 discretion of the commissioner or administrative law judge to whom the request for sanctions was
12 addressed.

13 (i) If at any time during the appeal with the medical director, the medical payment obligor
14 raises work relatedness, causation or non-compensability issues, the parties shall be advised by the
15 medical director that resolution of these issues requires a filing of an application for adjustment of
16 claim or Form 112, Medical Dispute, whichever is appropriate. The medical director, however,
17 shall continue with the appeal and issue a written determination of the reasonableness and
18 necessity of the proposed medical treatment consistent with this regulation.

19 (8) A determination by the medical director of the reasonableness and necessity of the
20 treatment, recommended treatment, or prescribed medication shall remain effective for six (6)

1 months from the date of the written determination of the medical director, unless a change in
2 condition is shown by objective medical findings.

3 (9) If the medical director's determination is to approve the medical treatment, the medical
4 payment obligor shall pay for the treatment, recommended treatment, or prescribed medication
5 within the thirty (30) day time period set forth in KRS 342.020(4) unless a Form 112, Medical
6 Dispute, is timely filed.

7 (10) If a party disagrees with the medical director's written determination, the aggrieved
8 party may file a Form 112, Medical Dispute, and proceed in accordance with 803 KAR 25:012.

9 (11) The filing of a Form 112, Medical Dispute, shall toll the thirty (30) day period for
10 paying medical expenses pursuant to KRS 342.020(4) until such time as the reasonableness and
11 necessity of the proposed medical treatment is decided by an administrative law judge.

12 (12) Failure to file a Form 112, Medical Dispute, within fourteen (14) calendar days shall
13 result in the written determination of the medical director having preclusive effect as to the
14 reasonableness and necessity of the treatment that is the subject of the medical director's
15 determination.

16 Section 18. Reconsideration and Appeals of Medical Bill Audit Decisions. A
17 reconsideration process to appeal an initial decision shall be provided within the structure of
18 medical bill audit.

1 (a) A request for reconsideration of the medical bill audit decision shall be made by an ag-
2 grieved party within fourteen (14) calendar days of receipt of that decision.

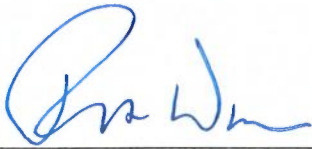
3 (b) Reconsideration shall be conducted by a different reviewer of at least the same
4 qualifications as the initial reviewer.

5 (c) A written decision shall be rendered within ten (10) calendar days of receipt of a request
6 for reconsideration. The written decision shall be clearly entitled "MEDICAL BILL AUDIT-
7 RECONSIDERATION DECISION".

8 (d) A request for reconsideration of the medical bill audit decision shall not toll the thirty
9 (30) day period for challenging or paying medical expenses pursuant to KRS 342.020(1).

10 ~~[(e) Any party may appeal the "MEDICAL BILL AUDIT RECONSIDERATION~~
11 ~~DECISION" to the medical director pursuant to Section 17 of this regulation.]~~

This is to certify that the commissioner has reviewed and recommended this administrative regulation prior to its adoption, as required by KRS 342.260 and 342.035.

A handwritten signature in blue ink, appearing to read "Rob Walker", written over a horizontal line.

Robert Walker, Interim Commissioner
Department of Workers' Claims

7-13-2021

Date

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation No.: 803 KAR 25:190

Contact person: B. Dale Hamblin, Jr, Assistant General Counsel

Telephone Number: (502) 782-4404

(1) Provide a brief summary of:

(a) What this administrative regulation does: This administrative regulation insures that insurance carriers, group self-insurers, and individual self-insured employers implement a utilization review and audit program and establishes a medical director to speed the delivery of payment of medical services to employees receiving medical and related benefits under this chapter. This administrative regulation does not abrogate the right, as provided in KRS 342.020, of an injured employee to choose his treating physician, or an employer to participate in a managed health care system.

(b) The necessity of this administrative regulation: To provide guidance to insurance carriers, group self-insurers, and individual self-insured employers with respect to utilization review, medical billing, and appeals to the medical director.

(c) How this administrative regulation conforms to the content of the authorizing statutes: KRS 342.260 provides that the Commissioner of the Department of Workers' Claims shall promulgate administrative regulations necessary to carry on the work of the Department of Workers' Claims, and the commissioner may promulgate administrative regulations not inconsistent with the provisions of KRS Chapter 342. KRS 342.035(5) provides that the commissioner of the Department of Workers' Claims shall promulgate administrative regulations

that require each insurance carrier, group self-insurer and individual self-insured employer to certify to the commissioner the program it has adopted to insure compliance with the medical fee schedule provisions of KRS 342.035(1) and (4). KRS 342.035(5) also requires the commissioner to promulgate administrative regulations governing medical provider utilization review activities conducted by an insurance carrier, group self-insurer or self-insured employer pursuant to KRS Chapter 342. KRS 342.035(6) allows the commissioner to promulgate regulations incorporating managed care or other concepts intended to reduce costs or to speed the delivery of payment of medical services to employees receiving medical and related benefits under KRS Chapter 342.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation helps to ensure timely benefits to employees through the use of utilization review. If the employee or medical provider disagrees with a utilization review decision, they are afforded the opportunity for a review by a neutral third party, the medical director. Because the medical director will be the one to decide appealed medical disputes, the resolution of appeals will be more consistent and the delivery of medical benefits more efficient.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: This amendment adds a new position and amends the method by which utilization review appeals are adjudicated.

(b) The necessity of the amendment to this administrative regulation: The medical director will more effectively assist the department in fulfilling its medical-related

responsibilities. Further, the amendment to this administrative regulation creates a medical advisory committee, which includes stakeholders from the various medical disciplines, to provide input on medical matters.

(c) How the amendment conforms to the content of the authorizing statutes:

The commissioner is required to promulgate administrative regulations necessary to govern the medical provider utilization review activities conducted by insurance carriers, self-insured groups, and self-insured employers. The amendment to this administrative regulation adds a person with medical expertise to help assure injured employees receive timely and appropriate medical benefits.

(d) How the amendment will assist in the effective administration of the

statutes: The addition of a medical director will help streamline medical decisions and help assure injured employees receive reasonable and necessary medical treatment in a timely fashion.

(3) List the type and number of individuals, businesses, organizations, or state

and local governments affected by this administrative regulation: Insurance carriers, self-insured groups, and self-insured employers.

(4) Provide an analysis of how the entities identified in question (3) will be

impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will

have to take to comply with this administrative regulation or amendment: The amendment to the administrative regulation directs the path taken by a utilization review appeal when appealed to the medical director.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): The medical payment obligor will pay \$400 for each appeal taken to the medical director.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Payment obligors will no longer be required to perform an in-house review of the requested medical treatment, which required the hiring of an independent physician to perform the review. The employee and medical provider will be afforded an independent review of requested medical treatment.

(5) Provide an estimate of how much it will cost the administrative body to implement this administrative regulation:

(a) Initially: \$350,000.

(b) On a continuing basis: \$350,000 per year.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The Department of Workers' Claims normal budget is the source of funding.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: The Department anticipates the fees will offset implementation costs.

(8) State whether or not this administrative regulation established any fees or directly or indirectly increased any fees: This administrative regulation does establish a fee.

(9) TIERING: Is tiering applied? (Explain why or why not) Tiering is not applied; the administrative regulation applies equally.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation No.: 803 KAR 25:190

Contact Person: B. Dale Hamblin, Jr. Assistant General Counsel
Dale.Hamblin@ky.gov

Telephone Number: (502) 782-4404

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? Those governmental agencies constituting a medical payment obligor for the purpose of workers' compensation.

2. Identify each state or federal statute or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 342.035(5) and (6), 342.260.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect. Without knowing the number of utilization review appeals that will occur, it is impossible to estimate the effect on expenditures.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? It is anticipated that approximately \$400,000 will be generated.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years?

It is anticipated that approximately \$400,000 will be generated in subsequent years.

(c) How much will it cost to administer this program for the first year?

Approximately \$350,000.

(d) How much will it cost to administer this program for subsequent years?

Approximately \$350,000 per year.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation: It is anticipated that the costs to administer the medical director appeal process will be offset by the fees generated so that the overall impact will be revenue neutral.

STATEMENT OF CONSIDERATION
RELATING to 803 KAR 25:190

Labor Cabinet, Department of Workers' Claims
(Amended After Comments)

I. The public hearing on 803 KAR 25:021, scheduled for May 27, 2021, at 10:00 a.m., to be held by videoconference by the Department of Workers' Claims, Mayo-Underwood Building, 3rd Floor, 500 Mero Street, Frankfort, Kentucky, was held by Interim Commissioner Robert Walker. Thirteen (13) written comments were received during the public comment period and nine (9) persons commented during the public hearing.

II. The following persons were noted as attendees or offered comment:

(a) Lisa Anne Bickford, Dir., Government Affairs, Mitchell/Genex/Coventry

(b) William V. Faris, JD, President, Occupational Managed Care Alliance, Inc.

(c) Christopher P. Evensen, Kentucky Workers Association

(d) Bill Londrigan, President, Kentucky State AFL – CIO

(e) Donna Little, Director of Health Policy and Regulatory Affairs, Kentucky Hospital Association

(f) G. Evan Jones, Attorney

(g) William Grover Arnett, Chad Jennings, Jeffrey A Roberts, Kentuckians for Economic Growth, LLC

(h) Jeffrey A. Roberts, Attorney

(i) Dr. Richard Brough DC, Kentucky Association of Chiropractors

(j) Kelly Reynolds, Branch Manager, Corvel Healthcare Corporation

(k) Ched Jennings, Attorney

(l) Susan R. Murdock, Executive Director, Association of Claims Professionals

(m) Alex O'Neil, Arbicare

(n) Kenneth A. Stoller, Senior Director, Workers' Compensation and Amicus Counsel,
American Property Casualty Insurance Association

(o) Rosalie Faris, Occupational Managed Care Alliance

(p) Mr. Ed O'Daniel, American Property Casualty Insurance Association

(q) Ken Eichler, CorVel Corporation

(r) Eric Lamb, Attorney

(s) Douglas Lamb, Attorney

(t) Andy Meserve, President, Owensboro Central Labor Council

(u) Bill Finn, State Director. Kentucky State Building & Construction Trades Council

(v) Bill Londrigan, Kentucky State AFL-CIO

(w) Bob Blair, President, United Food & Commercial Workers Local 227

(x) Chad Conley, President, Ashland Area Labor Council

(y) Charlie Maxwell, State Director, Communications Workers of America

(z) Cornelius Cotton, President/Business Manager, LIUNA Local 576

(aa) Ernest "Billy" Thompson, District 8 Director, United Steelworkers of America

(bb) Fred Zuckerman, President, Teamsters local 89

(cc) Greg Campbell, President, Stagehands Local 17

(dd) John Coomes, President, Try-County Council of Labor

(ee) Kindre Batliner, President, IUE/CWA local 8361

(ff) Kirk Gillenwaters, President, Kentucky Alliance for Retired Americans

(gg) Kyle Henderson, President, Western Kentucky Area Labor Council

(hh) Larry Wendler, President, IBEW Local 369

(ii) Robert Akin, President, Bluegrass Central Labor Council

(jj) Robert Smith, Secretary-Treasurer, NCFO/SEIU 32-BJ

(kk) Ron Richmond, Political Director, AFSC see Councilman 62's current McCarthy ME

Council 962

(ll) Ryan McCarthy, Business Representative, IAMAW District 1888

(mm) Scott Kenter, Business Manager, IBEW Local 212

(nn) Steve Earle, International Vice President, United Mineworkers of America

(oo) Tim Donoghue, President, Northern Kentucky Central Labor Council

(pp) Todd Dunn, President, United Auto Workers Local 862

(qq) Jeffery A. Roberts, Kentuckians for Economic Growth, LLC.

(rr) Dr. Nick Payne DC, Kentucky Association of Chiropractors

III. The following persons from the administrative body were present at the hearing or responded to comments:

(1) Robert Walker, Interim Commissioner, Department of Workers' Claims

(2) B. Dale Hamblin, Jr., Assistant General Counsel, Workers' Claims Legal Division

(3) Scott Wilhoit, Special Assistant to the Commissioner, Department of Workers' Claims

(4) John Ghaelian. General Counsel, Workers' Claims Legal Division

IV. Summary of Comments and Responses

(1) SUBJECT MATTER: Claims Selection Criteria and Process.

(a) Comment: Lisa Anne Bickford - The comment stated all needed utilization review documentation should be provided at the time of request and utilization review agents should be required to list all records considered in the event of a utilization review denial.

(b) Response: The administrative regulation was amended to require the medical director to obtain all the records reviewed by the utilization review physician and all related medical treatment records for a period up to two years prior to the utilization review.

(2) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Lisa Anne Bickford – The comment stated the proposed administrative regulation should be amended to restore the reconsideration process currently in effect.

(B) Response: No amendment was made in response to this comment.

(3) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Lisa Anne Bickford – The comment stated that, at a minimum, the proposed administrative regulation should be modified to restore the existing reconsideration process and allow the parties the opportunity to resolve disputes among themselves before involving the state medical director for further review or appeal; as proposed, the regulation undermines the effectiveness of the review processes built into the administrative regulations pertaining to the drug formulary and evidence-based treatment guidelines.

The following made a similar comment:

1. William V. Faris, JD, Occupational Managed Care Alliance, Inc.

(b) Response: After review, the Department believes the proposed administrative regulation will function in concert with the administrative regulations speaking to the treatment guidelines and pharmaceutical formulary. No amendment was made in response to this comment.

(4) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Lisa Anne Bickford - The comment stated the fee for utilization review appeals to the medical director was too high and should be reduced to \$250.00 and costs assigned to the non-prevailing party.

The following made a similar comment:

1. Kenneth A. Stoller, American Property Casualty Insurance Association
2. Ed O'Daniel, American Property Casualty Insurance Association

(b) Response: The Department believes assessing the fee to the non-prevailing party would raise constitutional and other issues and that the amount of the fee is reasonably calculated to offset the cost of the medical director process. No amendment was made in response to this comment.

(6) SUBJECT MATTER: Medical Director.

(a) Comment: Lisa Anne Bickford - The comment stated that in lieu of implementing a utilization review change at this time, a stakeholder group be convened to discuss potential changes to the utilization review process in a fashion similar to the groups created to discuss the pharmaceutical formulary and treatment guidelines prior to the creation of those administrative regulations.

The following made a similar comment:

1. Ed O'Daniel, American Property Casualty Insurance Association
2. Eric Lamb, Attorney

(b) Response: The Department has accepted and considered comments from stakeholders during the regulation process; those stakeholders hold differing viewpoints and the Department has attempted to include as many of those views as possible into the amended administrative regulation. No amendment was made in response to this comment.

(7) SUBJECT MATTER: Medical Director

(a) Comment: William V. Faris, JD - The comment stated the proposed administrative regulation did not include specific qualifications for the medical director program position; there was no provision requiring the medical director to be board-certified in their specialty. The comment further expressed concern that the medical directors specialty could be unsuited for the types of injury and occupational diseases common to workers compensation.

The following made a similar comment:

1. Kenneth A. Stoller, American Property Casualty Insurance Association

(b) Response: The administrative regulation was amended to include consultation with the Commissioner before an appointment would be made in an effort to assure the selected physician would have the requisite credentials, training, and experience for the position.

(8) SUBJECT MATTER: Medical Director.

(a) Comment: : William V. Faris, JD - The comment stated the proposed administrative regulation did not include a provision requiring the medical director to make decisions using the treatment guidelines adopted by the Department of Workers' Claims. Likewise, the comment noted that the medical director was free to use outside physicians to assist in decision-making; the comment expressed a concern regarding the credentials and specialties of the outside physicians. Finally, the comment expressed concern that the lack of a crystal-clear, scientifically-based guideline could result in an excessive prescribing of opioids.

(b) Response: The Department expects and anticipates the medical director to make decisions in keeping with the adopted treatment guidelines. The use of those guidelines would preclude the excessive prescribing of opioids. It is further expected and anticipated that any outside physicians used to assist the medical director would also make decisions in keeping with the adopted treatment guidelines.

(9) SUBJECT MATTER: Medical Director

(a) Comment: Christopher P. Evensen - The comment urged an amendment to allow the Commissioner of the Department of Workers' Claims to appoint the medical director rather than the Secretary of the Labor Cabinet.

1. Eric Lamb, Attorney

(b) Response: The administrative regulation was amended to include consultation with the Commissioner before an appointment would be made in an effort to assure the selected physician would have the requisite credentials, training, and experience for the position. The Secretary is the appointing authority for the Labor Cabinet under the current statutory scheme.

(10) SUBJECT MATTER: Medical Director.

(a) Comment: Christopher P. Evensen - The comment urged an amendment to require that the medical director must have spent more than 50% of his or her time actively treating patients in the 2 to 3 years prior to accepting the position.

The following made a similar comment:

1. Jeffery A. Roberts, Attorney

(b) Response: The administrative regulation was amended to include consultation with the Commissioner before an appointment would be made in an effort to assure the selected physician would have the requisite credentials, training, and experience for the position.

(11) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Christopher P. Evensen - The comment noted that the proposed administrative regulation stated that if the claimant or physician did not appeal the utilization review denial to the medical director within 30 days of receipt of the denial the claimant forfeited the right to such treatment. The comment opined that the 30 day deadline would cause many forfeitures.

As a basis for this concern, the comment noted that the adopted ODG guidelines contained three categories; approved, denied, or conditionally approved. The comment opined that conditionally approved meant the recommended treatment should be approved if certain factors were met or findings were present. The comment expressed concern that if the records provided to the doctor performing the utilization review did not contain the necessary factors, the utilization review doctor would issue an opinion denying the treatment at issue. As such, the claimant, and or

the claimant's attorney would have a very limited time in which to contact the physician and obtain the necessary documents before the 30 day deadline, creating a potential trap. As a consequence, the comment opined the claimant would lose before the medical director.

The comment urged a rebuttable presumption that treatment recommended by licensed Kentucky physician treating the injured worker be presumed to be reasonable and necessary and that the conditions are present for the treatment to be approved via the oh DG guidelines. Alternatively, the comment proposed that the claimant be allowed to initiate the appeal within the claimant's own time frame or to simply remove the forfeiture language so that failure to appeal to the medical director within 30 days did not forfeit the treatment at issue.

The following made a similar comment:

1. Eric Lamb, Attorney
2. Douglas Lamb, Attorney

(b) Response: The proposed administrative regulation was amended to allow 45 days in which to file an appeal rather than 30 days. Also, the proposed administrative regulation allows the medical director to extend the time to appeal for good cause; therefore, should a claimant require additional time to gather the necessary documentation the medical director has the authority to grant that extension of time.

(12) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Christopher P. Evensen - The comment noted that the proposed administrative regulation provided a 14 day period in which to appeal from a medical director's determination and, if no appeal was filed, the determination would have a preclusive effect as to

the reasonableness and necessity of the treatment at issue. The comment opined that this deadline would cause many unrepresented people to not file within the time deadline and that such a deadline was inconsistent with the two-year statute of limitations provided and workers compensation matters. Additionally, the comment stated that the proposed administrative regulation was vague and ambiguous as to whether denial of treatment at a particular time would preclude the same treatment under different circumstances at a later date. The comment opined that the failure to be more precise violated the injured worker's due process rights when there was a change of circumstance or new evidence.

(b) Response: The proposed administrative regulation allows the parties to file a medical fee dispute concurrently with an appeal to the medical director. As such, the proposed administrative regulation does not preclude the filing of a claim or an appeal to an administrative law judge. Similarly, the proposed administrative regulation specifically states that the medical director's decision pertains only to the treatment at issue and remains in effect for six months from the date of the written determination by the medical director unless a change in condition is shown by objective medical findings. No amendment was made in response to this comment.

(13) SUBJECT MATTER: Delay of Treatment.

(a) Comment: Christopher P. Evensen - The comment stated that currently in a pre-litigation claim, if treatment is denied by a utilization review, the claimant can request a utilization review appeal decision and, if still denied, the claimant can file a Form 101, causing the matter to be assigned to an administrative law judge. The administrative law judge would then determine if the recommended treatment is reasonable and necessary. In that circumstance, the claimant can file a motion for interlocutory relief. If the claimant is able to demonstrate through medical

evidence that the treatment is reasonable and necessary and that they will suffer irreparable harm they receive the treatment, the claimant will receive an expedited opinion regarding the treatment at issue. This expedited opinion is interlocutory and not subject to appeal. When the claimant is unable to meet the irreparable harm standard, the claimant can file a motion to bifurcate the claim and ask for a separate opinion from the administrative law judge determining whether the treatment is compensable. The comment stated that the establishment of the position of medical director created another layer in the utilization review process which would ultimately delay final determinations regarding the compensability of treatment.

(b) Response: the department has considered the comment and determined that the medical director will likely resolve the matter in a shorter period of time. Additionally, the claimant is not precluded from proceeding as described in the comment on all other issues except the reasonableness and necessity of the proposed treatment while simultaneously prosecuting an appeal to the medical director. No amendment was made in response to this comment.

(14) SUBJECT MATTER: Medical Director.

(a) Comment: Christopher P. Evensen - The comment noted that the proposed administrative regulation provided that the medical director was to set a date upon which all relevant information would be due. Additionally, the proposed administrative regulation required the medical director to make a determination of medical necessity within 14 days after receipt of all the necessary information; however, there was no specific time period set forth in which the medical director must require receipt of all relevant medical information. The comment opined that requests for extension of time in which to provide relevant medical information should be

controlled by an administrative law judge with legal experience as to what are appropriate grounds for an extension of time rather than a medical director.

The following made a similar comment:

1. Kelly Reynolds, CorVel

(b) Response: The proposed administrative regulation was amended to require the medical director within seven calendar days from receipt of the appeal to set a date on which all relevant information is due. Likewise, the proposed administrative regulation was amended to make it clear that the missing relevant information included all the records reviewed by the physician issuing the utilization review denial and all medical treatment records related to the injury for a period of up to two years.

(15) SUBJECT MATTER: Medical Director.

(a) Comment: Christopher P. Evensen - The comment noted that the proposed administrative regulation did not include a mechanism to seek interlocutory relief during an appeal to the medical director. The comment opined that this created an additional layer of appeal before the claimant could ask a judge for interlocutory relief, thus delaying treatment and may cause irreparable harm to the claimant. The comment further urged the addition of a provision that would require assignment of the case to an administrative law judge at the same time the matters appealed to the medical director.

(b) Response: The proposed administrative regulation does not preclude prosecuting a claim before an administrative law judge; this would include the ability to seek interlocutory relief. No amendment was made in response to this comment.

(16) SUBJECT MATTER: Medical Director.

(a) Comment: Christopher P. Evensen - The comment opined that a workers compensation insurance carrier continued to have the right to appeal an issue to an administrative law judge after the medical director had overturned a utilization review denial, causing the matter to go through the litigation process. The comment opined this created another level of appeal which would extend the time to decide the issue of entitlement to treatment. The comment urged a provision to provide there could be an appeal to an administrative law judge but the medical treatment determined by the medical director to be compensable would be applicable until such time as it is overturned on appeal.

(b) Response: The Department has considered the comment but believes the medical director's determination that a proposed treatment is reasonable and necessary will conclude most matters. For the few that may not be concluded by the medical director's determination, the party may concurrently prosecute a claim before an administrative law judge and have available any and all remedies currently available in that forum. No amendment was made in response to this comment.

(17) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Christopher P. Evensen - The comment expressed concern that if a claimant successfully challenged a utilization review denial the payment obligor might seek to begin the UR procedure all over again regarding any further treatment related to the successfully challenged utilization review denial.

(b) Response: The proposed administrative regulation provides that the medical director's determination shall remain in effect for six months from the date of the written determination unless a change in condition is shown by objective medical findings. No amendment was made in response to this comment.

(18) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Christopher P. Evensen - The comment opined that a \$400 penalty and section 17 (five) was unconstitutional because it was discriminatory; as such, the unenforceability of the sanction vitiated the entire medical director regulation and was a reason to declare it void. The comment urged an amendment to provide that it was the administrative law judge to whom the case was assigned or the commissioner pursuant to the unfair claims settlement practices regulation who decided on sanctions for violations of the new regulation.

(b) Response: The proposed administrative regulation does not assess a \$400 penalty in section 17 (5); rather, the proposed administrative regulation charges a fee of \$400 for each appeal submitted to the medical director. The confusion appears to stem from the reference to KRS 342.990 (7)(c) which does provide for a civil penalty to any person who fails to comply with the utilization review and medical bill audit administrative regulations. Those penalties are separate and apart from the \$400 fee for each appeal submitted to the medical director. No amendment was made in response to this comment.

(19) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Christopher P. Evensen - The comment opined that section 17 (7)(b) of the proposed administrative regulation allowed the medical director to base a decision on hearsay

statements of a medical provider because the attorney for the injured employee was not invited to participate, thus violating the sixth amendment right of confrontation in the seventh amendment right to counsel.

The following made a similar comment:

1. Eric Lamb, Attorney

(b) Response: The proposed administrative regulation does not allow the medical director to base a decision on hearsay statements; rather, section 17 (7)(b) allows the medical director to contact a medical provider for the purpose of obtaining necessary missing treatment records. No amendment was made in response to this comment.

(20) SUBJECT MATTER: Medical Director.

(a) Comment: Andy Meserve, President, Owensboro Central Labor Council

Bill Finn, State Director. Kentucky State Building & Construction Trades Council

Bill Londrigan, Kentucky State AFL-CIO

Bob Blair, President, United Food & Commercial Workers Local 227

Chad Conley, President, Ashland Area Labor Council

Charlie Maxwell, State Director, Communications Workers of America

Cornelius Cotton, President/Business Manager, LIUNA Local 576

Ernest "Billy" Thompson, District 8 Director, United Steelworkers of America

Fred Zuckerman, President, Teamsters local 89

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Kyle Henderson, President, Western Kentucky Area Labor Council

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**Ron Richmond, Political Director, AFSC see Councilman 62's current McCarthy ME
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Ryan McCarthy, Business Representative, IAMAW District 1888

Scott Kenter, Business Manager, IBEW Local 212

Steve Earle, International Vice President, United Mineworkers of America

Tim Donoghue, President, Northern Kentucky Central Labor Council

Todd Dunn, President, United Auto Workers Local 862

- The comment expressed support for the proposed administrative regulation because the reasonableness and necessity of medical treatment would be determined by medical doctors not administrative law judges. The comment further stated the proposed administrative regulation, by use of a medical director, would shorten the process for adjudicating medical disputes from the current 9 to 12 months to as little as 4 to 6 weeks. The comment further opined that by using a medical director there would be no need for the additional utilization review step of peer-to-peer review or additional delays in addressing the necessity of medical treatment for injured workers.

(b) Response: this comment supported the proposed administrative regulation as written; as such, no amendment was made in response to this comment.

(21) SUBJECT MATTER: Claim Selection Criteria and Process

(a) Comment: Donna Little - The comment noted that the proposed regulation amended thresholds that would trigger utilization review; the dollar threshold for total medical costs was reduced from \$3000 to \$1000 and the total lost work days was reduced from thirty (30) days to fifteen (15) days. As a result, the comment opined a higher number of claims would be subject to utilization review thereby increasing the burden on providers. Therefore, the comment urged that the proposed regulation be amended to increase the total medical cost to \$3000 and the number of lost workdays to 30 days before utilization review is triggered.

The following made a similar comment:

1. Kenneth A. Stoller, American Property Casualty Insurance Association
2. Dr. Richard Broeg DC, Kentucky Association of Chiropractors
3. Dr. Nick Payne DC, Kentucky Association of Chiropractors

4. Kelly Reynolds, CorVel
5. Ed O'Daniel, American Property Casualty Insurance Association
6. Ken Eichler, American Association of Payers Administrators and Network

(b) Response: The Department has considered this comment but has determined not to make amendment at this time based on this comment.

(22) SUBJECT MATTER: Medical Director.

(a) Comment: Donna Little - The comment noted the proposed administrative regulation established the membership of a new Worker's Compensation medical advisory committee. The comment requested the addition of a hospital representative on the advisory committee.

(b) Response: The proposed administrative regulation was amended to add a hospital representative to the Workers' Compensation Medical Advisory Committee.

(23) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Donna Little - The comment noted that section 17 of the proposed administrative regulation established a deadline regarding the failure to file a Form 112; however, the comment opined it was not clear to what the deadline related back.

(b) Response: In keeping with other applicable administrative regulations, following the medical director's determination the treatment at issue must either be paid within 30 days or challenged by filing a Form 112, Medical Dispute, within 30 days.

(24) SUBJECT MATTER: Reconsideration and Appeals of Medical Bill Audit Decisions.

(a) Comment: Donna Little - The comment noted that the proposed administrative regulation authorized a party to appeal a medical bill audit reconsideration decision to the medical director. However, the comment opined it was not clear which deadlines would apply because there was not a "written notice of denial" in a medical bill audit reconsideration.

(b) Response: The proposed administrative regulation was amended to remove the provision that appeared to create the confusion identified in the comment; the end result should be to restore the appeal procedure currently in use.

(25) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: G. Evan Jones - The comment noted that the proposed administrative regulation authorized the medical director to set a date on which all relevant information will be due to the medical director before making a determination. The comment expressed concern that the medical director being a physician, not a judge or attorney, may not have experience with what constitutes good cause for delay. The comment expressed concern that the lack of specificity in the proof timeline will end up delaying treatment because the proposed regulation did not limit how long the parties have to file all relevant medical information. The comment proposed that the administrative regulation be amended to set a precise number of days each party had to submit proof to the medical director.

The following made a similar comment:

1. Eric Lamb, Attorney

(b) Response: The proposed administrative regulation does not require the parties to submit proof; rather, the medical director is to be provided the same records that were provided to the utilization reviewer and up to two years of medical treatment records related to the injury giving rise to the denied treatment. It is only once the medical director observes that the provided documentation is incomplete that the medical director will request additional records. It is not a matter of the parties submitting proof to the medical director. The proposed administrative regulation was amended to make clear which records would constitute necessary relevant information necessary to the medical director's determination; only these records will be submitted to the medical director.

(26) SUBJECT MATTER: Medical Director

(a) Comment: William Grover Arnett, Kentuckians for Economic Growth

Jed Jennings, Kentuckians for Economic Growth

Jeffery A. Roberts, Kentuckians for Economic Growth

- The comment expressed support for the proposed administrative regulation as filed. The comment opined that the current utilization review program denied in 90% of proposed treatment; however, 80% of the utilization review denial determinations were subsequently overturned by an administrative law judge on appeal.

The comment noted the proposed administrative regulation required the medical director to obtain information that would monitor the effectiveness of the utilization review process and utilization review providers. Also, the comment observed the current utilization review process involved a review by a doctor under contract with the workers' compensation insurance carrier and

then reconsidered by another doctor also under contract with the workers' compensation insurance carrier. However, under the proposed administrative regulation only the initial utilization review would be done by a doctor who had a contract with the insurance carrier; the subsequent review would be performed by the medical director, a physician, completely independent of the insurance company and independent of the injured employee.

(b) Response: The comment provided support for the proposed administrative regulation as written; as such, no amendment was made in response to this comment.

(27) SUBJECT MATTER: Claim Selection Criteria and Process.

(a) Comment: Jeffery A. Roberts - The comment expressed the writer's experience; specifically recalling a time where the lack of medical treatment records had wrongly impacted a utilization review decision. As a consequence, the comment urged an amendment to the proposed administrative regulation that would require the medical payment obligor to certify it provided a complete copy of the medical treatment records for the injured employee for the last two years, or since the work-related injury, whichever was shorter, to the utilization review physician at the time the utilization review was initiated. The comment opined that doing so would eliminate medical fee dispute being filed unnecessarily and prevent the wrongful denial of medical treatment.

(b) Response: The proposed administrative regulation was amended to clarify that the necessary relevant information supplied to the medical director included the records reviewed by the physician that issued the utilization review denial and medical records for a period of up to two years preceding the utilization review related to the injury or occupational disease giving rise to the treatment, proposed treatment, or medication that was the subject of the utilization review.

(28) SUBJECT MATTER: Claim Selection Criteria and Process.

(a) Comment: Jeffery A. Roberts - The comment urged an amendment to the proposed administrative regulation that would require the medical payment obligor to send a copy of the utilization review decision to the injured employee's attorney, if an attorney is involved in the claim.

(b) Response: The proposed administrative regulation was amended to require the medical payment obligor to send a copy of the utilization review decision to the injured employee's attorney if the employee was represented.

(29) SUBJECT MATTER: Medical Director.

(a) Comment: Ched Jennings - The comment expressed support for the addition of a medical director in Kentucky's utilization review program. The comment opined that current timelines of 8 to 12 months for resolution of a medical dispute are projected to be reduced to as short a time as 4 to 5 weeks. The comment opined that the proposed administrative regulation was similar to one in Tennessee's workers' compensation program. According to the comment, the state of Tennessee averaged approximately 15,000 utilization reviews per year. Approximately 38% of the utilization review decisions were overturned or modified by the medical director and four (4) appealed for judicial review. The comment further stated the proposed administrative regulation, unlike the current system, required the reasonableness and necessity of medical care to be determined by a doctor instead of administrative law judges.

(b) Response: This comment stated support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(30) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Christopher P. Evensen - The comment expressed concern that if a claimant successfully challenged a utilization review denial the payment obligor might seek to begin the UR procedure all over again regarding any further treatment related to the successfully challenged utilization review denial.

(b) Response: The proposed administrative regulation provides that the medical director's determination shall remain in effect for six months from the date of the written determination unless a change in condition is shown by objective medical findings.

(31) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Susan R. Murdock - The comment expressed concern over non-meritorious or frivolous appeals. Specifically, the comment was concerned that payment obligor must pay \$400 for every fee irrespective of whether the appeal had merit or was frivolous or maliciously filed by disgruntled claimant. While objecting to the payment of any fee, the comment particularly objected to the payment of fees and non-meritorious appeals. The comment also objected to the proposal that a medical payment obligor could be exposed to a civil penalty when not paying the fee or missing the deadline to pay the fee. The comment provided a hypothetical that demonstrated the obligation to pay \$75,000 in fees for a single month. As an alternative, the comment urged the department to rely on the evidence-based medical treatment guidelines recently adopted. In short, the comment argued that the proposed administrative regulation incentivized the medical payment or obligor to avoid an appeal while at the same time increasing these incentive for an injured worker or a treatment provider to file an appeal in every instance.

The following made a comment similar to this:

1. Ken Eichler, American Association of Payers Administrators and Network

(b) Response: The Department has considered this comment but has determined not to make amendment at this time based on this comment.

(32) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Susan R. Murdock - The comment expressed concern that the proposed administrative regulation did not include a definition for “reasonable basis.” The comment opined this could create a circumstance where a medical payment obligor could deny a claim based on evidence-based medical treatment guidelines but also have no “reasonable basis” for denying the claim. As a consequence, the comment urged that the provision related to quote reasonable basis” be removed.

(b) Response: “Reasonable basis” is a term of art. If an evidence-based medical treatment guideline provided a basis to deny a claim there is “reasonable basis” to do so. The department has considered this comment but determined not to make amendment based on this comment.

(33) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Susan R. Murdock - The comment expressed concern that the proposed administrative regulation did not allow the opportunity for informal internal appeals as provided in other administrative regulations. The comment opined that allowing utilization review denial’s to work their way through an internal appeals process would result in fewer state-level appeals being filed. The comment urged the department to amend the proposed administrative regulation

to require peer-to-peer consultation as is required in other administrative regulations. The comment opined that a significant portion of the utilization review denials would be resolved through peer-to-peer discussion or by obtaining the appropriate medical records.

The following made a similar comment:

1. Ed O'Daniel, American Property Casualty Insurance Association
2. Ken Eichler, American Association of Payers Administrators and Network
3. Dr. Richard Broeg DC, Kentucky Association of Chiropractors
4. Douglas Lamb, Attorney
5. Rosalie Faris, Occupational Managed Care Alliance

(b) Response: The Department has considered this comment but has determined not to make amendment at this time based on this comment.

(34) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Alex O'Neal - The comment raised questions regarding the proposed appeals process and wondered if the department would consider a voluntary appeal process similar to that used in California. The comment also noted the disparity between the appeals process provided in 803 KAR 25:270 and the appeals process in the proposed administrative regulation.

The following made a similar comment:

1. Douglas Lamb, Attorney

(b) Response: the department has considered this comment but is determined not to make amendment at this time based on this comment. The department believes the workers compensation regulatory scheme in Kentucky and California are sufficiently different to require a different process.

(35) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Alex O'Neal - The comment questioned what criteria would constitute "good cause."

(b) Response: "Good cause" is a term of art. It is improbable, if not impossible, to attempt to list every scenario that would constitute good cause.

(36) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Alex O'Neal - The comment raised questions concerning the 15 day period in which the fee must be paid. The comment questioned whether the 15 day period would be based upon postmark and how the fee would be paid. The comment further opined that a late payment shouldn't mean an injured employee potentially gets treatment that isn't medically appropriate simply because a pay or failed to timely pay the fee.

(b) Response: The fee for each appeal is due 15 calendar days following the date of the appeal to the medical director. It is the date of the appeal that controls the beginning of the 15 day payment period. No amendment was made in response to this comment.

(37) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Alex O'Neal - The comment questioned whether "reasonable basis" had specific criteria. The comment further opined that differences of opinion would occur between reviewers and shouldn't warrant sanctions. The comment opined that sanctions should be in place for consistent and routine offenders for lack of reasonable basis or not following the required utilization review procedures; the medical obligor shouldn't have sanctions imposed if intentions and process were followed but the medical director had a different determination of medical necessity. The comment further stated that a two business day turnaround was insufficient time for potential peer-to-peer discussions between provider and reviewer. As such, the comment opined the tube business day turnaround time would likely create a higher appeal rate which is what the parties are attempting to avoid.

(b) Response: "Reasonable basis" is a term of art. It is improbable, if not impossible, to foresee and list all scenarios that would constitute "reasonable basis." Further, the Department does not believe a careful reading of the proposed administrative regulation would allow for the imposition of sanctions based solely on a different determination of medical necessity. While considered, no amendment was made in response to this comment.

(38) SUBJECT MATTER: Medical Director.

(a) Comment: Alex O'Neal - The comment noted the medical director may, when appropriate, seek the assistance of other physicians to assist in the tasks outlined in the proposed administrative regulation. The comment questioned what physicians would be involved?

(b) Response: It is improbable, if not impossible, to foresee all circumstances which may arise necessitating the need for additional input. However, an example would be where the treatment at issue involves chiropractic care but the medical director is not a chiropractor, the

medical director could contact a chiropractor for an opinion as to whether the proposed chiropractic care is reasonable.

(39) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Kenneth A. Stoller - The comment expressed concern that the proposed administrative regulation did not explicitly require written utilization review plans to incorporate the ODG by MCG treatment guidelines adopted by the commissioner. The comment opined that the ODG guidelines must be the basis not only for all utilization review determination but all appeals of utilization review determinations, with the ODG guidelines given a strong presumption of correctness on appeal.

The following made a similar comment:

1. Rosalie Faris, Occupational Managed Care Alliance

(b) Response: While the proposed administrative regulation does not explicitly require all utilization review plans to include the treatment guidelines adopted by the commissioner it also does not negate the adoption of those treatment guidelines or state the regulations pertaining to those treatment guidelines may be ignored during utilization review. It is expected that the involved parties will follow all administrative regulations promulgated under KRS Chapter 342, which would include the treatment guidelines. However, it is important to note that the treatment guidelines are guidelines and not a mandate. There may be circumstances under which deviation would be both reasonable and necessary. While considered, no amendment was made based on this comment.

(40) SUBJECT MATTER: Medical Director.

(a) Comment: Kenneth A. Stoller - The comment asserted that, like other states, the medical director should not be charged with the responsibility of adjudicating utilization review appeals; rather the most appropriate and effective role for the medical director at this point would be to chair a stakeholder working group charged with creating a comprehensive utilization review process. The comment further strongly urged the Department to look to guidance from other states. For instance, the comment stated that California had created a non-judicial process, the independent medical review, to address requests for medical treatment that had been delayed, denied, or modified through the initial utilization review process. This procedure did not include an agency determination. The California division of workers compensation contracted with independent medical review organizations to conduct independent medical reviews on its behalf. The comment asserted that such a process would seem far less susceptible to claims of bias from one group of stakeholders against another group than empowering a state appointee to make those determinations.

The following made a similar comment:

1. Rosalie Faris, Occupational Managed Care Alliance

(b) Response: Workers compensation regulatory schemes of various states are sufficiently diverse to require different approaches. It would appear from the comment that California has recognized that medical treatment is often delayed, denied, or modified by the initial utilization review process. California has elected to remedy that situation by contracting with independent medical review organizations. Kentucky has also recognized that medical treatment can be delayed, denied or modified through the utilization review process. However, Kentucky similar to other states, has determined that under its statutory workers compensation scheme the

use of a medical director will be more impartial, effective, and efficient. While considered, no amendment was based made in response to this comment.

(41) SUBJECT MATTER: Utilization Review and Medical Bill Audit Program.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment requested that appropriate language be added to the proposed administrative regulation that would require utilization reviewer's to meet the standards and requirements consistent with and not in conflict with the current statutes and regulations promulgated under KRS Chapter 342 and the appropriate Kentucky state licensing boards.

(b) Response: The Department does not believe the proposed administrative regulation contains a provision that would allow any party to disregard any applicable statute or regulation. The proposed administrative regulation was amended to state that when the treatment under appeal is chiropractic treatment the medical director shall seek the assistance of a chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.

(42) SUBJECT MATTER: Utilization Review and Medical Bill Audit Plan Approval.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the reporting measures contained in this section. The comment further provided strong support for the provisions requiring a written plan the supplied to the Commissioner for approval.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(43) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the information required to be contained in the written utilization review and medical bill audit plans submitted to the Commissioner.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(44) SUBJECT MATTER: Medical Director.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment strongly asserted that the medical director be appointed by the commissioner of the Department of Workers' Claims rather than the Secretary of the Labor Cabinet and serve for a term of four years. The comment opined that the position of medical director was a complex position requiring a thorough knowledge of the workers' compensation system and an in-depth knowledge of workers' compensation law as well as close interaction with the medical and legal personnel involved. The comment opined that greater continuity and longevity was required in the medical director position than was traditionally found in the position of the Secretary of the Labor Cabinet. As such, appointing the medical director for a term would provide better congruence and effectiveness between the legal and medical aspects of the current Kentucky workers compensation system.

The comment further stated support for allowing the medical director to, when appropriate, seek the assistance of other physicians to assist or perform any tasks outlined in the administrative regulation.

The following made a similar comment:

1. Rosalie Faris, Occupational Managed Care Alliance

(b) Response: The administrative regulation was amended to include consultation with the Commissioner before an appointment would be made in an effort to assure the selected physician would have the requisite credentials, training, and experience for the position. While the idea of appointing the medical director for a specified term has been discussed, it was decided not to amend the proposed administrative regulation at this time. The remainder of this comment was in support of provisions contained in the proposed administrative regulation as filed; therefore, no amendment was made.

(45) SUBJECT MATTER: Various point for clarification

(a) Comment: Kelly Reynolds - The comment expressed multiple questions seeking clarification of various provisions of the proposed administrative regulation, which will be answered as best the Department is able.

(b) Response: The first seven questions concern clarification of the existing administrative regulation. In response, the department states that the current understanding relating to those various provisions will continue until a new provision takes effect on June 1, 2022. Consequently, no amendment was made in response to these questions. With respect to the remaining questions, the Department states that a carrier is required to implement and maintain a utilization review and medical bill audit program, the information that a carrier is to provide the department for each fiscal year is due by August 1 of the same year, the name of the utilization reviewer is required in place of initials, especially when the reviewer is a physician. Further, the

department states that it recognizes a medical payment obligor may waive utilization review and approve a proposed treatment or medication. Similarly, KRS 342.020(4) provides a 30 day period for paying medical expenses; when the proposed administrative regulation speaks of tolling the 30 day period, it is this 30 day period of which it speaks. If known, the email addresses of the employee and medical provider are to be provided to the medical director so that the medical director can notify the employee and medical provider of the method to appeal a utilization review denial.

(46) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the information required to be contained in the written utilization review and medical bill audit plans submitted to the Commissioner.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(47) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the information required to be contained in the written utilization review and medical bill audit plans submitted to the Commissioner.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(48) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the information required to be contained in the written utilization review and medical bill audit plans submitted to the Commissioner.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(49) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the information required to be contained in the written utilization review and medical bill audit plans submitted to the Commissioner.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(50) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the information required to be contained in the written utilization review and medical bill audit plans submitted to the Commissioner.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(51) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the information required to be contained in the written utilization review and medical bill audit plans submitted to the Commissioner.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(52) SUBJECT MATTER: Utilization Review and Medical Bill Audit Written Plan Requirements.

(a) Comment: Dr. Richard Broeg DC, Dr. Nick Payne DC - The comment expressed strong support for the information required to be contained in the written utilization review and medical bill audit plans submitted to the Commissioner.

(b) Response: The comment was in support of the proposed administrative regulation as filed; therefore, no amendment was made in response to this comment.

(53) SUBJECT MATTER: General Comment

(a) Comment: Rosalie Faris - The comment opined the proposed administrative regulation would delay payment for medical treatment.

(b) Response: The comment expresses a general opinion for which no response can be generated; as such, no amendment was made in response to this comment.

(54) SUBJECT MATTER: Appeals of Utilization Review Decisions.

(a) Comment: Ed O'Daniel - The comment expressed support for moving post award medical disputes to the utilization review process.

(b) Response: The comment expresses a general opinion for which no response can be generated; as such, no amendment was made in response to this comment.

(55) SUBJECT MATTER: Claim Selection Criteria and Process.

(a) Comment: Ken Eichler - The comment expressed a belief that a five day period in which to render a retrospective utilization review may be too short.

(b) Response: No amendment was made in response to this comment.

(52) SUBJECT MATTER: Claim Selection Criteria and Process.

(a) Comment: Ken Eichler - The comment expressed a belief that the change in utilization review criteria would result in a huge volume of utilization review denials being submitted to the medical director, more than any one individual can handle.

(b) Response: The comment was considered but no amendment was made in response to this comment.

V. SUMMARY OF STATEMENT OF CONSIDERATION AND
ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The public hearing on this administrative regulation was held as scheduled. In addition, written comments were received. The Department of Workers' Claims responded to the comments and amends the administrative regulation as follows:

Page 3

Section 2. Implementation.

Line 19

After "before" insert "June" and delete "January".

Page 3

Section 2. Implementation.

Line 21

After "on or after" insert "June" and delete "January".

Page 17

Section 13. Claim Selection Criteria and Process.

Line 2

After "employee" insert ", and the employee's attorney if represented,".

Page 17

Section 13. Claim Selection Criteria and Process.

Line 11

After "employee" insert ", and the employee's attorney if represented,".

Page 19

Section 15. Written Notice of Denial.

Line 14

After “employee” insert “**, and the employee’s attorney if represented,**”.

Page 19

Section 15. Written Notice of Denial.

Line 18

After “employee” insert “**, and the employee’s attorney if represented,**”.

Page 20

Section 16. Medical Director.

Line 2

After “(1)” insert “**After consultation with the Commissioner the**” and delete “The”.

Page 20

Section 16. Medical Director.

Line 12

After “regulation.” Insert “**When the treatment under appeal is chiropractic treatment the medical director shall seek the assistance of a chiropractor qualified pursuant to KRS 312.200(3) and 201 KAR 21:095.**”

Page 21

Section 16. Medical Director.

Line 3

After “emergency medicine” insert “**, a hospital representative**” and after “and” insert “**a**” and after “pharmacy” insert “**representative**”.

Page 21

Section 17. Appeals of Utilization Review Decisions.

Line 13

After “shall have” insert “**forty-five (45)**” and delete “**thirty (30)**”.

Page 22

Section 17. Appeals of Utilization Review Decisions.

Line 20

After “missing information.” insert “**Necessary information shall be considered missing until the medical director has obtained:**

1. All of the records reviewed by the physician that issued the utilization review denial; and

2. All medical treatment records from the date of the injury or for the two year period preceding the date of the utilization review, whichever is shorter, for the injury or occupational disease giving rise to the treatment, recommended treatment, or prescribed medication for which the utilization review denial was issued.”

Page 22

Section 17. Appeals of Utilization Review Decisions.

Line 21

After “(c)” insert “**Within seven (7) calendar days from receipt of the appeal, the**” and delete “The”.

Page 23

Section 17. Appeals of Utilization Review Decisions.

Line 10

After “(g)” insert “**No later than two (2) days after the medical director has made a determination, the**” and delete “The”

Page 23

Section 17. Appeals of Utilization Review Decisions.

Line 12

After “employee” insert “**the employee’s attorney if represented**”.

Page 23

Section 17. Appeals of Utilization Review Decisions.

Line 13

After “Postal Service” delete “**within fourteen (14) calendar days after receipt of all necessary information by the medical director**”.

Page 25

Section 18. Reconsideration and Appeals of Medical Bill Audit Decision.

Line 15

Remove “(e) Any party may appeal the “**MEDICAL BILL AUDIT RECONSIDERATION DECISION**” to the medical director pursuant to Section 17 of this regulation.”.